Psychiatric Problems in Children

Part I of Two Parts

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IN preparing for this meeting* I have repeatedly asked myself the question, "What can I tell general practitioners about emotional, that is, psychiatric, problems of children which they do not already know?" Each time I mulled over the question, the same answer came, "Nothing!" This may or may not surprise you, but it is nevertheless true. In a very important sense, I cannot tell you anything from my special experience in child psychiatry which you do not already know from your own clinical experience. I can review with you—as I will in the face of this dilemma—more or less systematically those *concepts* of mental disorder in childhood which are more or less generally held and more or less generally accepted. I can, in other words, say something of our notions, or of our ideas of such syndromes of childhood as psychosis, neurosis and aggressive behavior disorder or psychopathy. I can delineate more or less concisely the characteristic symptoms or behavior of a child to which we — when we have to for various official purposes—give one of these diagnostic titles. This sort of discussion, I am sure, has some usefulness in refreshing your memories about the ideas you have heard and read in this field, and in giving you the feeling that there is some organized knowledge about these things. I can say something about what, at least I think, are some of the etiological factors in each of these syndromes and something about the more or less accepted methods of therapy of these conditions. This, too, may give you some notion of how we specialists struggle with these kinds of human problems. Perhaps some of you may even gain some encouragement to try to do something, or to do *more* of what you have already done, about such clinical situations in your practice.

Nevertheless, I am inclined to maintain that I cannot, in the brief time allotted, say very much, if anything, which will be useful to you, which you have not already experienced and which you have not already, in some sense, understood. In particular, I am dubious whether my talking to you will result in your being *better* able to do something about such illnesses and personality problems of children. Such doubt comes not only from what modesty I have about my competence and skill as a lecturer, but also and in a larger measure from the nature of the problem. I mean by this that therapy in psychiatry — particular psychotherapy, which I am inclined to think is the chief, if not the only, tool in child psychiatry—such therapy, I say, like any other specific skill in medicine is not generally learned merely by listening to someone else *talk* about it.

For this, practical work with patients *under trained supervision* is, I think, essential. Frankly, I think that if instead of these lectures we had discussion periods in which you participated actively, in which you could raise the questions about some of these problems with which you come here, in which each of you might share with the rest of us what success and what difficulties you had with such clinical problems in your practice, and so on, if we did this instead of your listening to these lectures, you might all leave with more gained. The method is gradually becoming a more generally accepted way of teaching such psychiatric skill as can be taught to groups.

Before going on to the more systematic discussion of psychiatric syndromes of childhood, we might return for a moment to the reasons for my pessimism about the utility of lectures in increasing the *clinical*, practical competence of the audience of such lectures. In the first place, it is my conviction that psychotherapy is a many-sided activity which involves not merely some technical knowledge and skill intellectually grasped, but the whole of one's own attitude about life. It involves one's own philosophy about not only what the goals of life are, but in particular also how these goals or ends of living are to be achieved. When I say philosophy, I do not mean merely some consciously and explicitly articulated explanation one can give to oneself or to others in words. I mean by philosophy a more or less thoroughly ingrained attitude which is implicit in one's *spontaneous* feelings towards one's own impulses, about one's social role, one's rights in relation to others. It is the *unthinking*, basic tendency about all aspects of living with others which is important in this kind of work. How one acts and feels towards oneself is what is finally tested by emotionally disturbed patients, and it is the nature of this self-regard of the physician which is the effective therapeutic influence.

My point in this connection is that all of us are variously affected by the world and what's happening in it. Our psychiatric patients, for good reasons

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in their early and current experience, are simply much more affected by the same general events and perhaps in a more deleterious direction. But to the extent that we, as physicians and as persons with variously fortunate past experience, are also in doubt, divided, more or less deeply in our convictions, beliefs and attitudes, we participate in those difficulties which our patients experience even more poignantly. To the extent that this is true of ourselves, we are to that extent less able to help our patients with *their* conflicts and doubts about themselves. And, by the same token, to the extent that we suffer from the same divisions in ourselves, in our own feelings, the less likely it is that such conflicts — which are often not clearly in our awareness — can be resolved by listening to someone talk about such things.

Unlike the experience of dissecting a cadaver to learn anatomy, of doing experiments upon animals to learn physiology, of looking at gross and microscopic specimens to learn pathology, the learning of psychopathology requires another process. This is a process of learning about one's own internal, subjective state, of how it came to be that way in one's own life's experience. This self-scrutiny and self-examination are not easy and rarely, if ever, sufficiently successful alone without the help of another, a trained person. It is, in brief, learning about one's own personality which is the most direct way of learning how to understand others.

It is for this reason that medical psychology seems intangible, strange, far-fetched, and the reason why it is difficult to grasp. Its material is inside ourselves, perceptible not only to our external but also to our internal sense organs, and hence elusive. Under these circumstances many of us feel this is not capable of "objective" examination, and hence not a proper subject for science. There is much more one could say about all this, but perhaps what has been said will suffice to suggest why I am inclined not to consider lectures as the most effective means of learning about feelings—good feelings, or bad feelings—which are finally what trouble our psychiatric patients—adults or children.

Let us review, then, first, the more or less distinct categories or types of disorders of feelings, thinking and action seen among children. I say "more or less distinct categories" because, as you all know, there is really no nosological entity, such as any diagnostic title implies, which corresponds very exactly with the disorder of any actually living person. The function of nosological concepts or ideas is to help organize *our* thinking about clinical phenomena in patients, and one needs always to be clear that *our ideas* or impressions of disorder need to be tentatively retained and discarded when the facts are no longer usefully explained by them. In psychiatry, but particularly in child psychiatry, this is especially true —and confusing to the unitiated. With this admonition about the concepts of disorder in childhood, let us consider some of these.

I would like to begin with neurosis. Neurosis in childhood, as in any other period of life, means that the child suffers from anxiety and that this anxiety is expressed and/or avoided by certain kinds of behavior. This behavior may be action (or lack of it) of the child in relation to other persons or evidenced in his subjective state and physiology, or more commonly in both ways. I do not suppose it is necessary at this point in the course for me to dilate upon anxiety. Perhaps I need only say that anxiety is that state of a human organism which appears to the onlooker as an extreme state of fear. We say it is extreme because the immediate external situation either does not seem to justify so intense a reaction at all, or the reaction appears disproportionate to whatever possible danger might be in it. In other words, anxiety is a reaction—subjectively the most disagreeable and unpleasant of human experiences—which is excessive, usually apparently unadaptive, and obviously indicates the operation of something in addition to the apparent *situation* around the child in which it is manifested. This additional factor which is internal to the child we call *conflict*. There is much to be said about conflict for which we do not have time. Perhaps the simplest definition might be that conflict is a state of self-opposition, of being impelled to behave in at least two diametrically opposite ways *at the same time*. As a few examples, we might cite the following: To run away and to fight or attack; to react with angry defiance and with ingratiating submission; to insist upon or to demand what one wishes and to give in and give up one's desire, and so forth. When such opposing impulses are of almost, or of about, equal strength, the human organism either vacillates between the two types of behavior, or there results a tense state of more or less total inhibition of all overt behavior. In any case, subjectively one experiences at such times *anxiety*, and because of such a dynamic division in oneself, one is more or less disabled, impotent in the face of some situation, and such relative helplessness itself increases the anxiety. You will note, however, that the internal physiological and internal subjective or psychological state even, and especially, in the state of more or less overt paralysis of action, is never one of smooth quiescence, but of considerable storm and turmoil.

Perhaps this will suffice to define briefly such terms as conflict, anxiety and the general dynamic state we call neurosis. If this condition is severe and chronic, that is, of some duration, there will be evident certain kinds of distortion of behavior of the child which will be characteristic for him alone, for his age, intelligence, physical equipment, his social and familial situation, and particularly for his experience in life up to that point. These distortions of behavior we tend to call the *symptoms* of the neurosis.

I do not need to enlarge upon the large and complicated variety of such neurotic symptoms in childhood. All of you have seen them in your clinical practice, heard of them, I am sure, as characteristic

of adult neuroses, and read of them as well. One might divide them very roughly into three great, but not therefore into any mutually exclusive, categories: (a) disturbances in physiology, (b) disturbances in the subjective or psychological state of feelings and thoughts, and (c) disorder of behavior in relation to other persons. I do not intend exhaustively to list the variety in each of these classes. A few examples from each will, I am sure, suffice to recall others you yourselves have seen clinically. Thus, under physiological disturbances all the systems and tissues of the body are capable of being affected. Gastrointestinal disorders from total loss of appetite as anorexia, finicky food habits, aversions or its opposite of bulimia and overeating, through nausea, vomiting, abdominal pain, to constipation or diarrhea and soiling, or a varying degree of failure to acquire toilet habits and sphincter control are among the commonest ills of children for which physicians are consulted. Skin disorders, respiratory difficulties, varying cardiac symptoms, genito-urinary troubles ranging from frequency and urgency to diurnal and nocturnal enuresis, headaches, as well as general weakness, are additional random examples which come to mind. Among the host of psychological symptoms, perhaps the commonest are various phobias, sleep disturbances with nightmares and terrors, but also inability to concentrate, with or without the appearance of obsessional thinking, and compulsive rituals. In the realm of interpersonal behavior perhaps the most frequently seen are varying degrees of avoidance of age-mates up to more or less complete withdrawal, as well as excessive submissiveness or ingratiating tactics with others.

To speak in this way of neurotic symptoms, even to illustrate them, however, is very unsatisfying to me. There is implied, in such a division of symptoms into categories, a criterion of classification which is invalid. One cannot even conceptually divide the human being into a physiological machine, a private psychological microcosm and a more public personality as we have just done without losing the essence of the unity which is the *person*, young or old. I mean quite simply that if we speak and think of children or adults in more or less impersonal, generalized terms, there is considerable likelihood—I was about to say *danger*—of losing the sense of a unique individual human being, with all the complexity of his characteristics, of his feelings, of his hopes, ambitions, desires and fears, of his particular relations with his family, with his friends and enemies at a given time in his life. In other words, all those personal qualities and facts of his current life situation which somehow "make sense" to those of us who are acquainted enough with these things about him, are apt either to be disregarded or lost in the generalized and theoretical constructions of such divisions of neurotic symptoms as I have just outlined. The danger of this loss of the sense of the individual, unique person lies in the failure of adequate diagnosis of his disorder and hence of inadequate therapy. But more about this later. And yet, unless we speak of a specific patient and all we may know or learn about him, some such generalizations are necessary in discussions such as this.

Hence, we may say, in general, that the neurotic child is apt to be the over-conforming, the over-obedient, the over-conscientious child. He is the child about whom it might be said that he is too "good" to be true, so "good" it hurts. He is the child who is a model, a mother's boy—or father's girl—perhaps extremely considerate (even over-considerate) of the feelings of others, and eager to excel in school and to please especially the important adults. He may be over-meticulous, orderly, punctual, over-polite in most respects. He may worry excessively about lessons, show perfectionistic tendencies in this direction and over-react to minor failures, errors, or—and especially—to the slights of people important to him with a mixture of depression or "hurt" feelings.

The neurotic child may—typically—rarely show, or even be able to feel, anger and frank resentment at such thwartings. Instead of some fight at any aggressiveness of his less inhibited playmates towards him, his tendency is towards flight, tears, and seeking of protection from adults. These tendencies infuriate his contemporaries even more who are then not only tempted to use him all the more as the butt of their envious rage at his "goodness," but also as one way to get back at the adults who protect him. Such experiences tend not only to drive the fearful, intimidated, neurotic child into avoidances of his possible playmates—into some degree of isolation and withdrawal, in other words—but also to even greater self-contempt and to still further lowering of his self-esteem and a more severe sense of estrangement. This increases the tendency to further vicious circles: Either to attempts at ingratiation, at buying some degree of tolerance from the bullying playmates by submission which increases their tendency to exploit and bully him more—or to efforts defensively to maintain a false attitude of indifference to their dislike which appears to them as an air of superiority which also keeps him isolated, unhappy and lonely.

When such events pile up in his life up to and beyond the limit of his tolerance, we see an eruption of a neurotic illness, of a crisis which expresses itself in poor sleep, nightmares, failure of appetite, fears of going out and to school, inability to concentrate on his lessons and hence failure to learn, and the innumerable other combinations of disturbances in total functioning. His school performance and his weight may decline and the pediatrician or the family's general practitioner may be consulted for his pallor, listlessness and general health. Although the physician may find hypertrophied tonsils, slight anemia or some degree of malnutrition, he may also be puzzled because these physical findings may not be present or only in slight degree, and what he may hear most about from an anxious and over-solicitous mother are the somatic complaints and less or

nothing about the rest of his other difficulties in living—unless he inquires about them.

Such, briefly, for the moment, is the general picture of neurotic illness in a child.

Before discussing what is in some respects the opposite clinical category of aggressive behavior disorder, let us consider now what I think is the extreme form of the neurotic illness, namely, the psychosis.

I must preface this brief outline of psychotic illness in children with a word about my own growing conviction—a bias, some might prefer to call it—as to its nature and etiology. I mean that, unlike some of my colleagues in the field, I am, on the basis of increasing, recent clinical experience, coming to the notion that these severe and often very chronic and quite frequently prognostically rather hopeless illnesses are the outcome of essentially the same, but more intense, factors operating earlier in the life of the child as those resulting in the milder neurotic and psychopathic disorders. In other words, I am inclined to consider and treat the psychoses of children as psychologically, rather than organically, determined. To put it in still another way, the psychotic way of life of a child is the outcome of, and an adaptation to, interpersonal stress, the difficulties experienced in living with the emotionally significant others around him. To place the emphasis etiologically upon the personal factors in the psychoses thus, is not to deny that impersonal factors (such as a congenital or acquired disease or defect of the brain or other parts of the body) may play a role. Such diseases or defects which handicap the child in comparison to his siblings or playmates and which decrease the satisfactions of his parents in his growth, appearance, etc., and increase their burden of his care, obviously are highly relevant factors. My point is, however, that there are many children with severe handicaps from such diseases *without* psychotic disorder in total living, and many psychotically disordered children in whom we find no identifiable evidence of such disease or defect. Finally, another and a critical bit of evidence is the fact that there is increasing data that psychotically ill children can improve if treated psychotherapeutically with sufficient skill, intensiveness and persistence.

I cannot here offer the details of the clinical evidence for this view of the genesis and nature of the psychotic illness. It is still such that the skeptical and the impatiently critical clinician will not be impressed. I must say, too, that there are many psychiatrists with considerable clinical experience with children who conceive and treat the psychoses of children as some rather obscure diseases of the encephalon and apparently without much hesitation use electric shock or insulin coma as treatment. There are others who make elaborate statistical studies to establish a genetic, hereditary etiology of the psychoses. Although you may conclude from such data as are recorded to support this contrary view that the whole question is far from being decided, I hope you will also give some consideration to the possibility which I advance here, namely, that the psychosis is essentially a more *neurotic neurosis* than the neurosis. Quite simply, I mean that the more severe, the more strange and often the more chronic disorder may be considered as one which is *qualitatively* different because of greater quantitative differences from what we so often defensively speak of as the *normal* personality development.

After this brief excursion into general conceptions of etiology, we may now outline, also briefly, the clinical picture of the psychosis of childhood. To begin with, one must say that, strictly speaking, the so-called mood or affective disorders, the manic-depressive psychoses, are rarely, if ever, encountered in childhood. Depressive reactions so severe as to lead to suicide are infrequent, at least, before puberty. The wide variety of strange and queer adjustments to life seen among prepubescent children are all, or most of them, likely to be called the schizophrenias of childhood. Disturbances in personality development so severe as to earn from the psychiatrist the diagnostic title of schizophrenia occur, or at least may be so classified, from the age of two years, and I know of no sex differential as to incidence. I am also unaware of any significant differences as to the ordinal position of the schizophrenic child. I mean that the child whose mode of living we may call schizophrenic may be the only child, the oldest, the youngest, somewhere in the middle of a series of siblings, or one of twins.

Because the particular schizophrenic child may show a bewildering concatenation of symptoms, let me discuss the general form of the disorder. One could describe the core of the schizophrenic disorder in several ways. One might say there is extreme failure in integration of the self; that self-opposition is so severe in respect to so many biological tendencies that there is little harmonious organization into a more or less stably coherent "I" or ego. One might say that the child is so extremely distrustful of himself and others, so extremely sensitive to rebuff from others, that he persistently prefers his own autistic world of reverie and bodily sensations rather than to expose, very often, his precarious self-esteem to the bruising inevitable in fuller living with others. One might say also that his self-hatred and hatred for others is so extreme and so dangerous that it necessitates not only constant efforts at magical control and disguise, but also estrangement and withdrawal from the world of living reality of others' probably retaliatory feelings. The wishes and desires of others—even if these coincide with one's own or are for one's own benefit—appear so autocratic or so smothering that blind and relentless, often gleefully self-destructive, opposition to them is not only imperative, but at the same time a unifying opportunity to assert oneself powerfully.

One could say all of these things and be partially correct in each of the statements. One can approach a more complete description of the core of what

Harry Stack Sullivan calls "the schizophrenic way of life"[5] by making all of these statements at the same time. So much depends upon one's position as a post of observation of what goes on: Whether one is, so to speak, on the sidelines watching the child and other persons with him; or whether one has penetrated as a therapist *into* the child's own subjective state *looking out* at the world of other persons around one or *looking in* to the welter of contradictory feelings and impulses within oneself.

In any case, in more ordinary parlance, the clinician sees the schizophrenic child as one who appears withdrawn, isolated, apparently indifferent — with flattened affect, as the textbooks say—to what goes on around him. At the same time, there are evidences of extreme, curiously incongruous and sometimes sudden phobias: Of a wheel on the wall of the dining room that has been hanging there many days; of the melody from the phonograph which has previously apparently been a source of delight and pleasure; of a phrase such as "too full" from the lips of another child in the dining room who comments about having eaten too much. There appear sudden, explosive, apparently unmotivated rages with flinging of chinaware on the floor, of a cat against the wall, killing it; kicking or striking a younger child or sitting on his prostrate body and pounding his head against the floor, or innumerable other violent eruptions of hostile aggression with cold, gleeful laughter at the results and just as sudden withdrawal into impenetrable gloomy, sullen speechlessness or queer posturing and whispering.

The clinician also sees without surprise pronounced disturbances in the most human form of communication with others—speech. There may be complete mutism which often raises doubts as to the inborn intelligence or the hearing of the child. There may be fragmentary speech, often with misuse or no use of the personal pronouns, and with peculiar inversions of word order. Speech may be in addition rather stilted or parrot-like as if devoid of emotional tone or interest. There may be peculiar intonations, jargon speech, neologistic tendencies or repetitious questionings which are either incongruous in a given situation or more or less completely incomprehensible. The schizophrenic child may be verbally unresponsive all day but suddenly and lustily sing in the night, waking the family. He may be seen whispering or talking to himself, voicing both the temptations to amoral behavior and his own severe admonition and condemnation of himself. The frequency of sense falsifications, of auditory or visual hallucinatory experiences, is not great in my experience. However, grossly careless and amoral or what is technically called "regressive" behavior with respect to bodily functions and habits is quite frequent. Thus, in addition to bizarre and intense food preferences and aversions, eating may be extremely messy and sloppy. Even more striking, soiling, smearing with feces, open defecations and urination everywhere except in the toilet, often occurs alternating with gleeful exhibitionism of the perineum or breasts, and genital or anal masturbation. The genitals or breasts of others may be the objects of sudden apparently unprovoked and coldly malicious attacks. Finally, the most striking characteristic is the almost impenetrable indifference to other children, and the extreme difficulty in establishing any very durable or very intense emotional tie to any but the most patiently sensitive but self-respecting, adult who would be the child's therapist. The outcome, as I mentioned previously, is all too frequently a hebephrenic type of deteriorated living, after puberty is established, in a mental hospital for the remainder of the patient's life.

This much must suffice for a very sketchy picture of the psychotic degree of illness in childhood. There remains the third and last nosologically identifiable group of psychiatric disorders of childhood, the aggressive behavior disorder which in its most severe form or during adolescence is also called the psychopathic personality disorder or incorrigible delinquency.

I have already said that this type of disturbance in personality development is in many respects the opposite of the neurotic disorder. In place of the fearful, rigidly conforming tendencies of the neurotic, we find the reverse — an extremely defiant, persistently egocentric impulsiveness to any action which gratifies the whim of the moment often in spite of any consequences to self. Even in the preschool age such a child is the bully of the playground, ruthlessly exploiting the younger and the weaker siblings or other children. Parents complain of the difficulty in controlling his rages, of his tendency to wander off or even run away from the home. In school—when he attends—he is the bane of the teacher's existence with his open or surreptitious disruptions of classroom routine, with his lack of interest in learning and his leadership in rebellions. His frequent truancies from school, although secretly, perhaps, a relief to his teacher, become a persistent problem to both the school attendance officer and to juvenile court probation officers as he extends the theater of his operations to other people and property of the community. Petty larceny or even burglary or forgery are the more frequent misdemeanors of the boy, while sexual delinquencies even with adults are the more commonly registered complaints against the girl. Failure of probationary trials at continuing to live in the home or elsewhere in the community after repeated appearance before the juvenile court judge leads too often to longer periods of internment in a reformatory or a state training school, release from which may be followed by no essential change in attitudes and behavior during the later adolescence or adult life.

So sweeping and rapid a characterization of this general type of disorder is more useful for identifying the clinical problem here than for understanding the particular, individual child whose inability to restrain or control his impulsiveness may finally bring him before a doctor, whether a psychiatrist

or not. The doctor may be surprised (after the story he hears about the child from the adults who bring him) to find often that the child is alert, spontaneous, even likeable in his engaging assertiveness. The child may even be rather frank about some of his behavior although quite apt either to lay the blame upon his teacher, his siblings or other grumpy adults, or he may—depending in part upon the tone and attitude of the questioning doctor—simply deny any knowledge of the reasons for his actions. If the doctor continues his acquaintance and contact with such a child, however, or is a trained observer, he will generally find under this first, apparently amiable and friendly surface a deep distrust that anyone really cares what he feels. The child most often indirectly and unwittingly, but at times quite clearly, reveals that he has felt cheated of the essential warmth of affection, and that he has experienced perhaps frequent, and even quite brutal punishment, but inadequate or inconsistent firmness. Hence, if one learns one cannot rely on adult steadiness to provide all those experiences which add up to a sense of belonging to a particular family group with definite rights, then one relies on opportunities and one's own skill for obtaining self-gratifications. Punishments for transgressions against obligations others wish to impose upon one, without adequate reward of deep approval and affection, are simply part of the necessary price of living and to be circumvented or avoided by any means at hand. Hence, punishments are other obstacles to getting what one wants; they are further evidence that no one cares and therefore reenforce the already deep sense of injustice. One is simply hardened into even more stolid and suspicious indifference by them; one tries next time to be more ingenious, if possible, in evading them and from the point of view of those to whom one's behavior is a headache, one learns nothing from the penalty and the strictness, although one may even promise to act differently in the future.

All this is not to say that some of these children, especially those from relatively stable homes, show no guilt or no evidence of some tendency to self-restraint. Even some of those with less fortunate familial circumstances manifest what is at the moment obviously sincere regret and remorse. When, however, the next time some disappointment at the hands of the important but often unnoticing adult occurs, the impulsiveness frequently proves to be stronger than whatever self-restraining tendency they may have integrated. The discouragement and impatience of the adults around the child after such an episode serves then often to deepen his own discouragement with himself although pride may permit nothing but sullen, defensive defiance to appear on the surface, and this evokes an even more hopeless impotent fury in the adult who feels he cannot reach the child or understand him.

If some of the child's impulsiveness, usually provoked in some subtle way which does not appear in the report, expresses itself in some blindly revengeful attack upon a person, then the doctor is asked or asks himself whether or not there is some encephalitic or perhaps epileptic disorder. The electroencephalogram is then sometimes read as showing a generalized cerebral dysrhythmia which offers some room for clinical interpretation of possible epileptic equivalent. If the child learns something of this either directly or from the hesitant attitude of the doctor, or from other adults thereafter, his impulsiveness is apt to be increased because there seems to be an additional reason why one cannot help what one does, now almost with medical sanction.

Such, then, are some of the general characteristics of this more or less identifiable syndrome of aggressive behavior disorder. There are other and quite individual tendencies which may be unique to a given child, but however variable in degree, the common difficulty is in living more or less peacefully with authority, within the more or less accepted mores, customs and standards of behavior. The psychiatric textbooks speak of the psychopathic personality in various terms such as "moral imbecile," "constitutional psychopathic inferior," emphasizing that although intelligence may be, and often is, average or above — sufficient, in other words, for the patient to be able to say verbally what is right or wrong—there is a peculiar and persistent inability to learn from even bitter experience. There is in such discussions also considerable emphasis upon the emotional immaturity of such a person, upon his failure to develop the capacity to postpone gratification for longer term goals in living. Essentially what is meant here is the person's varying degree of failure to identify himself with whatever ideals of community living are prevalent for the common welfare of himself and the others with whom and through whom he can obtain his satisfactions. Again, the notion that this disorder is the expression of some cerebral or other constitutional, that is, genetically transmitted defect of somatic equipment, is frequently encountered in such treatises on this subject. And once more I must raise doubts regarding such pessimism about etiology and prognosis. Although therapeutic results as regards very basic and durable modifications of such personality organizations in many instances are certainly extremely difficult to achieve, and prognosis therefore is certainly always guarded, I think nevertheless, that in every instance I have been able to study sufficiently closely there have been always adequate conditions in the postnatal, interpersonal experience to account for our failure to integrate such a person into our society's way of living.

This is Part I of an article in two parts. Part II, with a table of references, will appear in a succeeding issue.